North Carolina Department of Health and Human Services
Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Steven Jordan, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
Craigan L. Gray, MD, MBA, JD, Director

September 7, 2010

MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray

Steven Jordan SJ

SUBJECT: Implementation Update #78
CAP MR/DD Update
Providers of TCM–IDD
Update on TCM–MH/SA
Medicaid Reimbursement Rate Update
CST Revised Limits
Medicaid Recipient Notifications
LME UR Update
UR Adverse Determination Letters
CABHA Transition Data
CABHA Business Ownership

CAP-MR/DD Update

Waivers Development Stakeholder Survey
We are interested in stakeholder feedback on the development of the CAP-MR/DD Tiered Waivers system which includes revision of the current CAP-MR/DD Medicaid waivers and creation of the new waivers. During the month of September, all interested stakeholders have the opportunity to participate in a survey about the CAP-MR/DD Medicaid waivers. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA) will consider all responses as we continue to improve the waivers to be implemented in November 2011. Your feedback is very important to us and we want to hear from individuals receiving CAP-MR/DD waiver services, parents and guardians of individuals receiving services, service providers, advocates or others having direct experience with the current CAP-MR/DD waivers.

This survey uses Survey Monkey and all responses are anonymous. To participate in the survey, go to http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm and follow the instructions provided there. Thank you in advance for sharing your perceptions and recommendations. Remember all responses are due by September 30, 2010.

Correction to Implementation Update #76
In Implementation Update #76, posted July 7, 2010, under "**Implementation Plan for the CAP-MR/DD Clinical Policy, CAP MR/DD Comprehensive Waiver and Supports Waiver Manuals and Technical Amendment Number One**,**"** paragraph three**,** it was incorrectly noted that notices of adverse action/due process of appeals rights must be mailed at least 30 days prior to the effective date of the adverse action. **The correct time frame is that notices must be mailed at least 10 days prior to the effective date of the adverse action. Please note this correction.**

Supports Intensity Scale
As part of the DMH/DD/SAS Supports Intensity Scale (SIS) implementation, UNC-Chapel Hill is recruiting a SIS Coordinator for the project. The job posting can be found at http://jobs.unc.edu/2500294.

Providers of Targeted Case Management for Individuals with Intellectual and Developmental Disabilities
DMA has received approval to implement a new procedure code and rate for Targeted Case Management for individuals with intellectual and developmental disabilities (TCM-IDD) for direct enrolled providers. Effective with date of service August 1, 2010, or the date of enrollment, whichever is later; direct enrolled providers may be reimbursed for T1017HE at the new weekly rate of $62.26. T1017HE may be billed only by the direct enrolled providers. HP Enterprise Services will not process any systematic recoupment of T1017 HI and repayment for code of T1017 HE.

Provider Enrollment Information
The effective date of enrollment for direct enrolled providers for TCM-IDD will be the date requested by the provider but no earlier than August 1, 2010, or the date a complete and accurate enrollment package is received by Computer Sciences Corporation (CSC), if a date is not requested by the provider.

Until providers are directly enrolled with DMA, they may continue to bill TCM-IDD services through the local management entities (LMEs) with T1017 HI and T1017 HI SC, at the current rate of $17.67 per unit. Effective January 1, 2011, LMEs will no longer process TCM-IDD claims for Medicaid.

For state-funded TCM-IDD the process is the same as with Medicaid TCM-IDD. When the state-funded provider receives its enrollment number from Medicaid, that provider should inform the LME with whom the provider is contracted to provide TCM-IDD as soon as that number is received.

Service Authorization
This service must be prior authorized for non-CAP Waiver recipients prior to submitting claims. (TCM for CAP Wavier recipients does not require prior authorization.) Following enrollment, the provider will be able to request authorization for TCM-IDD for new non-CAP Waiver recipients in accordance with current procedures and documentation requirements. Providers may fax authorization requests to ValueOptions at 877-339-8754. For current recipients with an existing authorization, providers may request transfer of authorizations from T1017 HI to T1017 HE and transfer of the authorization from an LME to their TCM-IDD Medicaid provider number through the ValueOptions' TCM Provider Change Request Form at http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm. ValueOptions will authorize the new code as requested and begin the authorization start date on August 1, 2010, or the actual provider enrollment date, whichever is later. There will be no charge to providers for this transfer of authorizations.

Documentation
Documentation must reflect each contact. A full service note for each contact, or a full service note for each date of service (if there are multiple contacts within a day), written and signed by the person(s) who provided the service, is required. For more details on what to include in the service note, please refer to the Records

Management and Documentation Manual,
http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/rmd09/rmdmanual-final.pdf

Additional Claims Processing Information

Claims Submission: The billing limit is one unit per week which runs from Sunday to Saturday. If the claim identifies a span of dates, (e.g. August 2-6, 2010), the claim will be denied. In order to bill, providers must provide at least 15 minutes of service per week. The service must be provided and documented according to the needs of the recipient. Electronic claims submitted by direct enrolled providers prior to the 8/19/2010 cutoff for procedure code T1017 HE will have adjudicated on the 8/26/2010 check write. Claims processed after the 8/19/2010 cutoff will adjudicate according to the current check write schedule. **Please note:** system audits have been developed to deny claims billed with T1017 HE or T1017 HI if billed during the same calendar week. The first claim processed and paid for a recipient will result in the denial of any other claim for TCM during the same week.

Electronic Funds Transfer: Providers must submit to HP Enterprise Services a completed Electronic Funds Transfer (EFT) form specific to TCM-IDD. Claims will suspend if this EFT form is not on file. Although many providers have completed the enrollment process and been issued a Medicaid provider number, many have not completed an EFT Authorization Agreement for Automatic Deposit form needed for payment. You can access the form from DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Update on Mental Health/Substance Abuse Targeted Case Management

Weekly Rate

As per Implementation Update #77, Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) has a weekly (Sunday-Saturday) case rate. In order to bill this weekly rate, case managers must provide at least 15 minutes of case management activity (assessment, person centered plan (PCP) development, linkage/referral, monitoring) per week. The case manager shall provide all services necessary to meet the case management needs of the recipient. Many recipients may require more than 15 minutes of case management activity per week. With the weekly case rate, a provider may only bill once per week, although a case manager might provide services for a recipient multiple times in a week. Providers should not bill for each 15 minute contact. Providers should not bill over a span of dates. Providers may bill only once (one date) per week when at least 15 minutes of case management activity have been achieved. Example: if a case manager has a 15-minute contact with a recipient on Monday, the provider may bill the weekly rate for that week on Monday. If the case manager provides additional case management services throughout that week, the provider cannot bill again for any date in that same week (Sunday-Saturday). The weekly case rate covers ALL case management activities for the week and all dates of service for that week.

Documentation

Documentation must reflect each contact. Per the service definition, a full service note for each contact, or a full service note for each date of service (if there are multiple contacts within a day), written and signed by the person(s) who provided the service, is required. For full requirements of the service note, please refer to the DMA Clinical Coverage Policy 8L, http://www.ncdhhs.gov/dma/mp/8L.pdf

Medicaid Provider Number/National Provider Identifier

MH/SA TCM is a service that can only be provided by a Critical Access Behavioral Health Agency (CABHA). Once a provider is certified as a CABHA, they will need to complete the NC Medicaid Enrollment application. The downloadable enrollment application is available on the NCTracks website, (http://www.nctracks.nc.gov).

For CABHAs not yet enrolled: In order to enroll to provide MH/SA TCM, the provider must check the appropriate box (TCM for MH/SA) on page four of the application. Please indicate the national provider identifier (NPI) associated with MH/SA TCM in the space provided. This NPI can be the same as the NPI associated with your CABHA NPI or it can be a different NPI. If the CABHA does not indicate an NPI, CSC will automatically link the MH/SA TCM Medicaid provider number (MPN) to the NPI associated with the CABHA MPN. When a CABHA is issued a CABHA MPN, they will also be issued a state-wide MH/SA TCM MPN. **This state-wide number is an interim number. In the future, CABHAs providing MH/SA TCM will be issued site-specific MPNs. There will be more information posted in upcoming communications.**

The MH/SA TCM MPN will be used to request prior authorization for the service. When billing, the CABHA NPI will be the billing provider number on the CMS 1500 claim, and the MH/SA TCM NPI will be the attending number on the claim. Unless the CABHA has indicated a different NPI for the MH/SA TCM MPN, both NPIs (billing and attending) will be the same on the claim form.

For enrolled CABHAs: CSC will be contacting providers who have already enrolled as CABHAs to assist them with obtaining a MH/SA TCM MPN. **This state-wide number is an interim number. In the future, CABHAs providing MH/SA TCM will be issued site-specific MPNs. There will be more information posted in upcoming communications.** CSC will automatically link the MH/SA TCM MPN to the NPI associated with the CABHA MPN. If an already enrolled CABHA wishes to choose a different NPI for their MH/SA TCM MPN, they will need to submit a Medicaid Provider Change Form and a copy of the NPPES letter for that NPI to CSC. The MH/SA TCM MPN will be used to request prior authorization for the service. When billing, the CABHA NPI will be the billing provider number on the CMS 1500 claim, and the MH/SA TCM NPI will be the attending number on the claim. Unless the CABHA has indicated a different NPI for the MH/SA TCM MPN, both NPIs (billing and attending) will be the same on the claim form.

Medicaid Reimbursement Rate Update

DMA has been instructed by the NC Department of Health and Human Services (DHHS) Secretary to reverse the proposed rate reductions that were effective September 1, 2010. Notwithstanding any further directives, the rates in effect as of August 31, 2010 shall remain in effect on September 1, 2010, and thereafter. DMA is in the process of replacing the published September 1, 2010, fee schedules with the previously published fee schedules. The Fiscal Agent has been instructed to continue with the current rates on and after September 1, 2010. If you have any questions, please call the DMA Finance Management Section at 919-855-4180.

Community Support Team Revised Authorization Limit and Effective Date

As a reminder, all new authorizations for Community Support Team (CST) shall be based upon medical necessity as defined by DMA Clinical Coverage Policy 8A and shall not exceed 32 hours (128 units) per 60-day period for adults. Existing authorizations for CST will remain effective until the end of the current authorization period. Please note that maintenance of service (MOS) authorizations will not exceed the benefit limit of 32 hours (128 units) per 60 days for adverse decisions appealed on or after September 1, 2010. As a reminder, children under the age of 21 may qualify for this service if medically necessary under Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Medicaid Recipient Notifications of Mental Health/Substance Abuse Benefit Changes

Medicaid and N.C. Health Choice recipients are notified of benefit and coverage changes through monthly mailings. Copies of the notifications are available on DMA's website at http://www.ncdhhs.gov/dma/pub/consumerlibrary.htm.

Prior Authorization of Medicaid-funded Mental Health, Developmental Disability, Substance Abuse Services by The Durham Center and Eastpointe LME

As indicated in Implementation Update #77 and the August 2010 Medicaid Bulletin, as of September 20, 2010, all providers for recipients with Medicaid eligibility within The Durham Center's catchment area (Durham County) will be required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to The Durham Center for prior authorization. All providers for recipients with Medicaid eligibility within Eastpointe's catchment area (Duplin, Lenoir, Sampson, and Wayne counties) will be required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to Eastpointe for prior authorization. This change will apply only to providers delivering services to recipients with Medicaid eligibility in those catchment areas.

Effective September 20, 2010, ALL CAP requests, including revision requests, must be sent to the appropriate LME utilization review (UR) vendor for processing; recipients with eligibility in Durham Center's catchment area must be sent to the Durham Center and recipients with eligibility in Duplin, Lenoir, Sampson, and Wayne Counties must be sent to Eastpointe. As a point of clarification, requests for additional units of CAP/MR-DD services above the current authorized amount are considered "revision requests." When submitting CAP/MR-

DD revision requests or provider change requests for CNRs that have been approved by ValueOptions (VO), the targeted case managers are required to submit the following documents:

1. A complete revision request including CTCM forms, cost summary, and signature page, as well as any other documentation required per service definitions.
2. A complete copy of the last CNR packet including cost summary, signature page, and MR-2.
3. Copies of any revisions that were approved by VO after the last CNR and prior to the revision being requested.

Note: All concurrent requests for non waiver I/DD TCM must continue to be sent to VO until December 31, 2010. All new non-waiver requests from I/DD TCM providers, who will continue to request authorization for T1017 HI and bill through an LME, must continue to be sent to ValueOptions. Initial requests for non-waiver I/DD TCM made by direct enrolled providers for new recipients with no prior authorizations on file should be sent to the UR vendor for their county of eligibility (i.e. VO, Eastpointe, or the Durham Center) as of September 20, 2010. The LME UR vendors can only authorize the new weekly code (T1017 HE) for direct-enrolled I/DD case management providers.

Effective September 20, 2010, for mental health/substance abuse services, providers should submit requests for "additional units" to VO for processing if VO originally approved the initial or concurrent request. In other words, if a recipient with eligibility in the Durham Center or Eastpointe catchment areas needs the authorization of additional units for a mental health/substance abuse services request that was authorized by VO prior to September 20, 2010, that request should be **faxed** to VO for processing (this request **should not** be submitted through ProviderConnect). It is important that the request be clearly labeled as a request for "additional units" to ensure that it is processed appropriately by VO in a timely fashion.

Note: For those certified CABHAs that have a Community Support authorization and plan to use the MH/SA TCM attestation process outlined in Implementation Update #77, these attestation letters must be sent to VO for end-dating the Community Support authorization and starting the MH/SA TCM authorization. Eastpointe and The Durham Center **WILL NOT** be able to process these attestation requests. All requests (initial and concurrent) for Community Support authorizations should continue to be sent to ValueOptions until December 31, 2010. All initial requests for MH/SA TCM for recipients in The Durham Center's and Eastpointe's catchment areas, should be sent to The Durham Center and Eastpointe, respectively IF the provider will not be using the attestation process. Concurrent requests for MH/SA TCM should be sent to the appropriate UR vendor (i.e. VO, Eastpointe, or the Durham Center) for the recipient's catchment area.

Remember that all NC Health Choice service requests throughout the state are to continue to be submitted to ValueOptions for prior authorization.

DMA Behavioral Health Policy	ValueOptions	The Durham Center	Eastpointe LME
919-855-4290 telephone	1-888-510-1150 telephone	919-560-7100 telephone	1-800-913-6109 telephone
	1-877-339-8753 fax number for MH/SA requests	919-560-7377 fax number for MH/DD/SA requests	910-298-7189 fax number for MH/DD/SA requests
	1-877-339-8754 fax number for DD requests	919-328-6011 fax number inpatient/PRTF requests	910-298-7184 fax number inpatient/PRTF requests
	1-877-339-8760 fax number inpatient/PRTF requests		

Prior Authorization Changes: Adverse Determination Letters (Reduced or Denied Requests)

Adverse determination letters will no longer include recommendations for alternate services. The new Adverse Determination Letters will advise that recipients may also be eligible for other Medicaid services and recipients may talk with their physician, other licensed clinician, or provider to determine if other Medicaid services are appropriate.

Critical Access Behavioral Health Agency and Single Business Ownership

This serves as a clarification of CABHA structure and ownership requirements. All CABHA enhanced and residential services must be under the single business ownership of the CABHA. All staff who provide residential and enhanced services for the CABHA must be employees of the CABHA. Individual enhanced or residential service sites cannot provide services for more than one CABHA. Individual, direct-enrolled behavioral health practitioners (i.e., LCSW, LPC, LMFT, APN) of "core" services—outpatient therapy, assessments, and medication management—may be employed by multiple CABHAs.

Upon receiving the certification letter from DMH/DD/SAS that certifies their agency as a CABHA, the CABHA must complete and submit the In-State/Border Organization Provider Enrollment Application to enroll. **When completing the Affiliated Provider Information section of the application, the CABHA must list:**

- The name, MPN, and NPI associated with that number for each individual, direct-enrolled behavioral health practitioner (i.e., LCSW, LPC, LMFT, APN) who will provide 'core' services for the CABHA.
- The name, attending MPN (identified by the alpha suffix appended to the core number), and the NPI associated with that number for each enhanced service site owned by the CABHA.
- The name, attending (site) MPN, and the NPI associated with that number for each residential service site owned by the CABHA.

Upon successful enrollment, CABHAs will be issued one statewide CABHA MPN. Although a CABHA could obtain a subpart NPI for each of their service sites, Medicaid can only have one NPI associated with an MPN. Therefore, CABHAs will need to identify one NPI to associate with the CABHA MPN and use that NPI when submitting claims for core and enhanced services. CABHAs do NOT need to associate all enhanced and residential service sites with this NPI. Providers may keep the same NPI that is currently associated with all their enhanced and residential service sites.

Authorizations will NEVER be made to the CABHA's MPN. All claims for core and enhanced services must be submitted with the NPI associated with the CABHA MPN as the "Billing Provider" and the NPI associated with the direct enrolled provider or enhanced service site MPN as the "Attending Provider" on the professional claim format (CMS-1500/837P). As stated in Implementation Update #73, as a reminder, all Therapeutic Foster Care (Level II-Family Type) must continue to be submitted through the LME for processing as they are done today. For Level II-Program Type, III or IV, claims should be submitted with the residential child care facility (RCC) billing NPI number and not the CABHA NPI number

Please refer to Implementation Update #73 for full enrollment authorization, and billing guidelines.

CABHA Transition Data

Two reports have been developed to assist in planning and facilitating a smooth transition for individuals who will need Community Support Team (CST), Day Treatment (DT), or Intensive In-Home (IIH) services after December 31, 2010, at which time these services can only be provided by CABHAs. These reports, the Service Continuum for CABHA Applicants at the Verification Stage Report and the Service Authorization Report, have been posted on the CABHA web page (http://www.dhhs.state.nc.us/mhddsas/cabha/index.htm). Both reports will be updated at least once a month.

Please note that in order to produce an unduplicated count of providers and individuals served, certain personal identifying information (PII) and personal health information (PHI) were used in the preliminary analysis, however, all PII (e.g., employer identification numbers and provider #s) and PHI (e.g., the recipient's Medicaid ID #) were redacted before these reports were posted. Due to the size of the reports, they have been bookmarked to assist in navigating through each report for a specific analysis.

Following is a description of the Service Continuum Report and the Service Authorization Report:

Service Continuum for CABHA Applicants at the Verification Stage

This report verifies the array of services for which a provider is enrolled. This information is derived from the DRIVE provider enrollment database. Pages 1-24 of this report identify the location (region) of the CABHA certified site, the core services provided, those services that can only be provided by a CABHA (i.e., CST, DT,

and IIH), the MH/SA services provided by age/disability group, and other services provided by each of the **CABHA certified providers** and **CABHA applicants that are at the verification review stage**. Pages 25-26 list all the CABHA certified providers and CABHA applicants that are currently at the verification review stage.

In order to maintain the integrity of the data, this report is based on enrollment status as authenticated in the DRIVE database (i.e., the service(s) for which the provider is enrolled). For those providers that are adding services, the service continuum for that provider will be updated when a provider number is issued for the new service(s) as opposed to when the provider is endorsed to provide the service.

Individuals with Authorizations for Community Support Team, Day Treatment and Intensive In-Home
The purpose of this report is to project the number of individuals with authorizations for CST, DT, and IIH who will need to be served by a CABHA once non-CABHA certified providers are no longer able to provide these services. This report is taken from the ValueOptions Service Authorization Report. It gives a breakdown of the number of individuals within a county or LME catchment area who are authorized to receive CST, DT or IIH. "County" is based on the recipient's county of Medicaid eligibility – not the county where the service is located. In the individual-specific section of this report (i.e., the last three bookmarks), an address is given for the provider, however, this may or may not be the site-specific address (e.g., it could be a post office box or the address of the corporate office). The LME will be able to assist in determining the location where the service is currently being provided.

The term "**CABHA**" indicates that ***a provider has been certified or is at the verification review stage***. The term "**Non-CABHA**" indicates that ***a provider has not applied or is in the process but not yet at the verification review stage (CABHA-Pending)***.

The summary page (pages 1-3) shows the number of individuals receiving one of the three services by county, LME and region.

The second set of data (pages 4-137) identifies providers and the total number of individuals currently in treatment with that provider. This report is broken down by county and differentiates CABHA applicants (pages 4-25) from all other providers (pages 26-71). Pages 72-137 combine all CABHA and Non-CABHA providers.

The third set of data (pages 138-886) identifies which services an individual is enrolled in. Each row represents an individual receiving the service. The data is broken down by provider name and also differentiates CABHA (pages 138-266) and Non-CABHA providers (pages 267-512). Pages 513-886 combine all CABHA and Non-CABHA providers.

The LMEs are coordinating the transition process at the local level. All providers – both certified CABHAs and non-CABHA providers – should collaborate with the designated LME contact for assistance. The successful transition of consumers requires a joint effort and teamwork among providers and the LME.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
Michael Watson
Beth Melcher
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Jim Slate
Sharnese Ransome
Lisa Hollowell
Shawn Parker
Melanie Bush
Pam Kilpatrick
John Dervin
Kari Barsness
Lee Dixon